REPORT OF THE GROUP PURCHASING WORKING GROUP

TO THE URBAN HOSPITAL COUNCIL

92-05814/

TABLES OF CONTENTS

	Summary of Recommendations	1
1	The Existing Program	2
2.	Program Effectiveness	4
3.	The Proposed Program	6
4.	Implementation Plan	10
5.	Conclusion	10

Appendix A	Committee Organization - Group Purchasing Services
Appendix B	Existing Regional Supply Programs
Appendix C	Operating Expense Per Patient Day By Type of Expense for Reporting Public Hospitals - Canada and Provinces, 1988-89 (Statistics Canada)
Appendix D	Supply Analysis 1989-90 ($Million)
Appendix E	Proposed Model
Appendix F	Proposed Committee Structure

REPORT OF THE GROUP PURCHASING WORKING GROUP

TO THE URBAN HOSPITAL COUNCIL

On April 15, 1991 a Working Group of five persons was identified to develop proposals to "improve group purchasing". The specific terms of reference were to:

> "1. Review the current group purchasing practices for hospital supplies in Manitoba
>
> 2. Identify available options for increasing the cost savings in group purchasing
>
> 3. Identify an implementation plan for any recommended changes in group purchasing practices."
>
> (Communication to H. Willkie from F. DeCock, Executive Director, MHSC, dated April 11, 1991)

The group was provided with a time frame of one month to prepare and submit its recommended course of action. The short response time permitted three conference calls and two intensive face-to-face meetings. Findings, drawn from knowledge and experience rather than research and consultation, are summarized in the Summary of Recommendations.

Summary of Recommendations

1. Change the program's organization, mandate, reporting relationships, and operations to create a cohesive and agile group purchasing program, guided by materiel management professionals with the objective to achieve full committed volumes from the 10 urban facilities.

2. Require that the Materiel Management Committee explore the implications and feasibility of introducing the prime vendor type concept into the MHO program, where appropriate.

3. Accelerate implementation of automated systems and procedures in the program.

4. Develop and implement a supplier rebate or pay-back system to provide incentives for compliance, and in time, to completely offset assessments.

5. Establish annual targets for savings, monitor program performance and conduct annual assessments of program effectiveness.

6. Maintain/expand the regional supply programs to ensure that the needs of all rural acute and long term care facilities are met.

1. THE EXISTING PROGRAM

Manitoba Health Organizations, Inc. has been operating a voluntary group purchasing program for the benefit of its member facilities for over two decades. The program has evolved gradually to its current organization and size.

1. The attached Committee organizational chart (Appendix A) describes its governing structure.

   Briefly, the Policy Committee is a committee of the MHO Board, and chaired by one of its members. It is composed of administrators from urban and rural facilities, and the Chairmen of the Purchasing Services and Pharmacy Committees. The Committee's function is to set policy and oversee the program. Reporting to this Committee are the operational committees, namely Purchasing Services (med/surg supplies, etc.) and Pharmacy (Pharmaceuticals). A third layer of subcommittees, eg. Laboratory, Radiology, Dietary, Pharmacy Tender Opening, etc., report through the Purchasing Services and Pharmacy Committees to the Policy Committee. The operational groups are composed of facility staff who have specialty knowledge of the particular supply category.

2. The program administers contracts whose total annual value is $21.11 million. Product categories are medical/surgical, pharmaceutical, dietary, radiology and laboratory supplies, with annual values of $6.7M, $6.7M, $2.6M, and $1.4M, respectively.

3. There are 114 facilities participating in the program. Participants include acute and long term care facilities from urban and rural Manitoba. Certain urban facilities have organized Regional Supply programs to assist small rural facilities in overcoming purchasing barriers, such as minimum orders, etc. (see Appendix B).

4. The group purchasing process requires intensive membership input. By formal motions at committee meetings, MHO staff are instructed regarding contract awards. Existing documentation outlines the process, its timelines, the program's Guiding Principles, and contract terms and conditions.

5. The program is supported by 3 EFTs: a Manager, Contract Coordinator and Program Assistant. For the 1990/91 fiscal year, the MHO Group Purchasing Program had a budget of $167,477.00. The actual cost recorded for 1990/91 can be summarized as follows:

Salaries (3 EFT approved budget but not staffed at this level for the full fiscal year)	$ 78,000.00
Travel (Rural representatives to meeting included)	15,400.00
Staff Training and Professional Fees	3,300.00
Maintenance	2,400.00
Printing	10,000.00
Miscellaneous	8,000.00
MHO overhead costs (Space, Computer Support, etc.)	46,400.00
Amortization & General Expense	2,844.00
TOTAL	$166,344.00

The above costs were covered through an assessment levied against hospitals in the Group Purchasing Program. In the 1991/92 fiscal year, the assessment will be $8.92 per EFT, with a minimum charge of $275.00 and a maximum charge of $24,900.00.

2. PROGRAM EFFECTIVENESS

A working definition of "group purchasing" was determined to be the process of consolidating purchase requirements (volumes) through grouping of buyers and/or product standardization to achieve lower prices in tendering. The assumption is that vendors are willing to offer lower prices if given commitment over time to larger market shares.

How is Manitoba group purchasing performing presently? There is general agreement that the Manitoba Group Purchasing Program, started in the early 1970's, has contributed to lower pricing. However, there are some broad indicators both quantitative and qualitative that would indicate further improvement is desirable.

In reviewing data from Statistics Canada published in the CHA's Canadian Hospital Directory, 1989-90, Manitoba shows as the highest province in cost for supplies per patient day (See Appendix C). When comparing non-salary costs as a percentage of total costs per patient day, Manitoba is the highest at 30%. Though one can debate the grouping of supply categories and the usefulness of "patient days" as the denominator, Manitoba still lies at the wrong end of the scale. Alternatively, one could argue that the higher expenses are due to higher usage per patient versus higher supply costs. If that were so, then a direction other than price should be pursued in curtailing expenses.

Another way to evaluate the effectiveness of group purchasing is to determine the percentage of dollars that are under contract (see Attachment D).

Experience and informed opinions generated the following assumptions:

1. The ten urban hospitals represented at least 75% of provincial health dollars; and

2. MHO's annual contract values can be accurately determined by using "straight-line" calculations.

Analysis of the five major contract categories, laboratory, drugs, medical/surgical, radiology and dietary, was done utilizing the data from MHO and MHSC. For these major supply categories, less than 25% of total provincial dollars are under contract. Drugs (30.2%), dietary (30.5%) and radiology (45.0%) do better than the average, with medical/surgical and laboratory supplies at the other end of the scale at 15.7% and 14.6% respectively.

Some explanation for this low proportion under contract can be obtained by analysing user behaviour. It is noted that the basic premise of group purchasing is being violated when all facilities do not participate with the same level of commitment, e.g., some facilities do not submit volumes or understate their usage. This confirms the observation that all participants at the operations level, particularly the materiel managers, do not share a common philosophy of obtaining maximum benefits for the group as a whole.

Rather, a more local philosophy seems to prevail, that is, to maximize benefits for the individual facility. To compound this, group contract volumes are tendered at only 85% of survey volumes. Materiel managers have noted that such practices most certainly compromise "best price" contracts.

Limitations related to program administration are also apparent. Additional computer and staff resources are required to manage information volume due to the increasing range of program activities. Operational changes to make full use of technological changes has not occurred, and major urban facilities have not experienced the man-hour savings that are expected to accrue from their participation in an effective group purchasing program. Consequently, the urban facilities, which bear most of the membership fees and purchase most contracts at 70% to 90% of the volume, are resisting increased fees to expand the program as it is currently structured.

Finally, the program's focus to try to meet the needs of all facilities, regardless of size, is not perceived as worthwhile for the large facilities.

In summary, the program's effectiveness has declined over time due to the inefficiencies originating from the structure and process of a voluntary program and its inability to utilize technological improvements.

3. THE PROPOSED PROGRAM

Our objective is to improve a program that has been developed over 25 years and that has served the hospitals well. In essence, the task is to restructure the program to eliminate or minimize its deficiencies while utilizing the considerable expertise, talent, and energy of urban facilities materiel management personnel.

This model, Appendix E, recognizes the following:

1. About 75% of total provincial health care supply costs are attributable to the ten urban facilities;

2. There can be 100% contract utilization for certain agreed-upon products;

3. MHO's committee membership can be changed to reduce the costs of representation and to empower major purchasers to make decisions;

4. Program efficiency can be enhanced by providing a forum for a smaller, more cohesive group of materiel handling professionals to coordinate their expertise for the benefit of all member facilities; and

5. More cohesive leadership and governance will result in a program that can be more easily modified to meet the needs of the large users while providing additional benefits to small rural acute and long term care facilities.

Program Organization

Recommendation #1: Change the program's organization, mandate, reporting relationships, and operations to create a cohesive and agile group purchasing program, guided by materiel management professionals with the objective to achieve full committed volumes from the 10 urban facilities.

It is proposed that the structure and process be simplified by the elimination of the Group Purchasing Policy Committee and by the change at the operational level to a much smaller committee with input from the ten urban hospitals (see Appendices E & F) viz. Concordia Hospital, Victoria General Hospital, Misericordia General Hospital, Seven Oaks General Hospital, Grace General Hospital, Brandon General Hospital, St. Boniface General Hospital, Health Sciences Centre, Deer Lodge Centre and Winnipeg Municipal Hospital.

The teaching hospitals should be encouraged to cooperate in the procurement of the tertiary program products that are unique to them and information should be shared between the teaching and other urban hospitals to ensure maximum participation in all contracts for the benefit of all facilities.

The mandate and operations of the program's committees should be modified and widened, where appropriate.

The Materiel Management Committee would assume the following role:

- set policy for the program, oversee and coordinate its activities
- develop and implement procurement arrangements
- negotiate major contracts on behalf of members
- implement standardization of products across hospitals
- delegate routine contract negotiations to sub-groups of materiel managers or purchasing agents
- evaluate and monitor program effectiveness
- monitor compliance
- monitor the fee structure and manage the supplier rebate program
- report to MHO Board, and maintain regular reporting liaison with the Urban Hospital Council

The committee should be allowed to use a full range of contracting and negotiating techniques and systems. Contracts should be negotiated when tendering is not the best procedure for finalizing an agreement, as flexibility may be required relative to terms, etc.

In view of their combined volume, concentrated efforts must be made to ensure that both teaching facilities participate in as many contracts as possible. By having a tight and agile group committed to managing contracts for full utilization, better contracts and contract prices should be achieved. Contracts should enable suppliers to accommodate deficiencies in shipping costs for both location and volume. For example, it should be acknowledged that Health Sciences Centre can take truckload shipments of certain products.

The Committee may elect to designate 2 or 3 individuals to handle routine contracts such as plastic bags, etc., rather than involve the full Committee. Also, certain basic products, such as toilet paper and garbage bags, should be standardized for all ten facilities with requirements established for full compliance.

Recommendation #2: Require that the Materiel Management Committee explore the implications and feasibility of introducing the prime vendor type concept into the MHO program, where appropriate.

The focus on line contracts should be changed to multi-products, multi-vendor and prime vendor contracts as may be appropriate. Informal investigations have revealed that many buying concepts already are being utilized by facilities under the catch all phrase "Prime Vendor" with the net intent of effecting savings through reduced procurement costs, i.e. labour and material.

Experience has shown that in an effort to gain a wider share of the market, suppliers are actively pursuing expansion of the concept and now utilize several marketing strategies to entice buyers into purchasing a broader range of commodities with projected benefits for both the buyer and seller, e.g. stockless purchasing, rebate programs, discounts, etc. Facilities that have entered into these various programs would appear to have benefited financially to various degrees.

Program Operations

Recommendation #3: Accelerate implementation of automated systems and procedures in the program.

There is a high degree of computerization in urban facilities and maximum benefit should be achieved to minimize the burden of information flow and tabulation, and maximize the generation of useful information. The trade off would be lower MHO group purchasing fees, far less paperwork, as well as a wider variety of good contracts.

Fee Structure

Recommendation #4: Develop and implement a supplier rebate or pay-back system to provide incentives for compliance and in time, to completely offset assessments.

The Group Purchasing Program should be a service to a participating hospital's purchasing function providing clear advantages and reasons for compliance.

It is acknowledged (under "Program Effectiveness", p.4) that specific activities by hospital members were considered to be detrimental to the overall success of the Group Purchasing Program. To encourage active, positive participation, hospitals should have the ability to recover any costs assessed them. This may be accomplished by the MHO Group Purchasing Program actively soliciting rebates or cash-backs. These monies would then be credited against participating hospital assessments in ratio to their percentage of participation, i.e. 10% of contract volume would net a participating hospital 10% of the rebate monies. These monies would be paid at the end of a fiscal year and would be credited against the following year's assessment.

This method of pay-back to participating hospitals would encourage hospitals to avail themselves of the benefits of group purchasing and could contribute to the program's ongoing development as required.

In the long term, the program should move towards a total pay-back system while reducing its dependence on the existing EFT-based assessments.

Regional Supply Programs

Recommendation #5: Maintain/expand the regional supply programs to ensure that the needs of all rural acute and long term care facilities are met.

The procurement practices of small rural acute and long term care facilities include participation in MHO's program, participation in regional supply programs organized by certain urban facilities, and purchases from their community suppliers. This range of choice should be preserved, recognizing the unique political and economic requirements of the average rural facility. Specifically, their access to the MHO program would be achieved in either or both of two ways:

a) through direct purchase from MHO contracts; or

b) through indirect purchase from MHO and other facility contracts using expanded regional supply programs organized by the urban facilities.

Accountability for Program Performance

Recommendation #6: Establish annual targets for savings, monitor program performance and conduct annual assessments of program effectiveness.

The changes proposed increases the materiel managers' accountability for developing and guiding implementation of an effective program. Success will be dependent on the skills, abilities and willingness of the materiel managers to be innovative and to collaborate with each other based on their facility's known philosophy and commitment towards participation in group purchasing.

Essentially, accountability will rest with both materiel managers and their CEO's. Jointly, they would establish annual targets for expected program savings. Achievement of this and other important program goals would be monitored during the year by the Materiel Management Committee with regular reports to the Urban Hospital Council. At least annually, formal reports should be submitted to the Council providing information related to the program's progress towards standardization, value of rebates achieved, value of contracts, degree of compliance demonstrated, and the amount of savings achieved.

A joint process of evaluation such as this would facilitate ongoing program modification to establish and maintain effectiveness.

4. IMPLEMENTATION PLAN

The following are suggested actions for implementation to be undertaken by the Urban Hospital Council. Allowing for unplanned delays, the changes could be finalized for implementation in September, 1991.

		Timing/ Duration
1.	Distribute the Report for information to the MHO Board and existing Group Purchasing Committees, namely, the Group Purchasing Policy, Pharmacy and Purchasing Services Committees.	Immediate
2.	Identify one person to oversee and trouble-shoot, as appropriate, the transition process and provide regular progress reports to the Urban Hospital Council.	Immediate
3.	Develop a communication strategy to advise all facilities of the proposed changes and their implications.	One month
4.	Request the urban facilities' materiel managers, with MHO support, to propose a plan of action with timelines for implementing program changes.	Two months

5. CONCLUSION

Benefits accruing from participation in the MHO group purchasing program can be enchanced by improving its operations, increasing the role of materiel managers and incorporating new procurement concepts.

The working group is pleased to have had the opportunity to develop this plan and are available to provide any additional information or assistance as required.

Respectfully submitted,

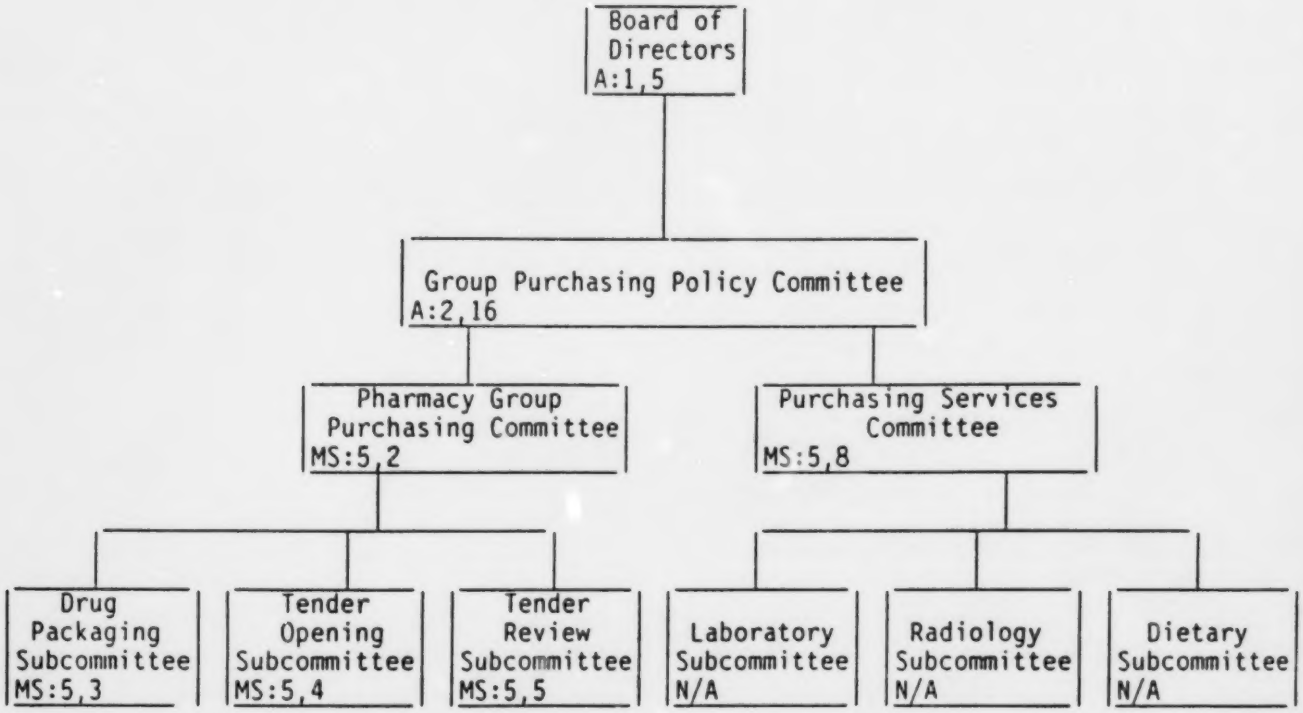
Hila Willkie

GROUP PURCHASING WORKING GROUP

H. Willkie (Chair)
B. Hill
M. Kirkpatrick
G. Moreland
T. Woodward

ADMINISTRATIVE MANUAL	Subject: COMMITTEE ORGANIZATION	No: MS:5	Page: 1.5
	Department: GROUP PURCHASING SERVICES	Approved By:	
	Effective Date: MAY 1991	Supercedes: MARCH 1989	

Group Purchasing Services, Committee Organization Chart



NOTE: Number of Committee Members by Committee

Group Purchasing Policy Committee	-	15
Pharmacy Group Purchasing Committee	-	14
Purchasing Services Committee	-	15
Drug Packaging Subcommittee	-	3
Tender Opening Subcommittee	-	4
Tender Review Subcommittee	-	4
Laboratory Subcommittee	-	13
Radiology Subcommittee	-	12
Dietary Subcommittee	-	12

EXISTING REGIONAL SUPPLY PROGRAMS -

ARRANGEMENTS BETWEEN AN URBAN FACILITY AND SMALL RURAL FACILITIES

Misericordia General Hospital

- Tiger Hills Health District
- Baldur Health District
- Altona Health Centre
- Glenboro Health District
- Notre Dame Hospital
- St. Claude Hospital

Seven Oaks General Hospital

- Arborg Health Centre
- Johnson Memorial Hospital
- Stonewall & District Health Centre
- Pine Falls General Hospital

Dauphin General Hospital

- Roblin District PCH
- St. Rose General Hospital
- Grandview District Hospital
- McCreary/Alonsa Health Centre
- Winnipegosis General Hospital
- Swan River Valley Hospital
- St. Paul's Home
- Benito Health Centre
- Dr. Gendreau PCH

Brandon General Hospital

- Birtle District Health Centre
- Boissevain Health Centre
- Cartwright District Hospital
- Dakota Oyate Lodge
- Dinsdale Personal Care Home
- Erickson District Health Centre
- Foyer Notre Dame
- Hamiota District Health Centre
- Lorne Memorial Hospital - Swan Lake
- Minnedosa District Hospital
- Notre Dame Medical Nursing Unit
- Reston Hospital
- Riverdale Hospital - Rivers
- Rock Lake Hospital - Crystal City
- Rock Lake Personal Care Home - Pilot Mound
- Rossburn District Health Centre
- Sandy Lake Medical Nursing Unit
- Shoal Lake - Strathclair Health Centre
- Souris District Hospital
- Hartney Medical Nursing Unit
- Tri Lake Health Centre - Killarney
- Virden District Hospital
- Elkhorn Nursing Unit
- Wawanesa District Hospital

Abstracted from CHA's Canadian Hospital Directory, 1989-90

TABLE 6.5.2 Operating Expense[1] Per Patient Day (Adults and Children) by Type of Expense for Reporting Public Hospitals, Canada and Provinces, 1987-88[2]

TABLEAU 6.5.2 Dépenses de fonctionnement[1] par jour/patient (adultes et enfants) selon le type de dépense dans les hôpitaux publics répondants, Canada et provinces, 1987-1988[2]

Canada and/et Provinces	No. of Hosp.[3]/ Nbre d'hôp.[3]	Oper. Expenses/ Dép de fonct. Total $'000	Total $	Gross Sal., Wages/ Rémun. brute $	Empl. Benefits/ Avantages soc. $	Supplies, Other Expenses/ Fourn., autres dép. $	Med., Surg. Supplies/Fourn. méd., chir. $	Drugs/ Médicaments $
Canada	987	16,757,059	355 51	226 86	24 77	67 06	15 49	11 47
Canada (Excl. Qué.)	814	12,523,793	366 68	229 53	25 38	69 41	16 75	12 03
Nfld./T.-N.	41	360,279	453 27	281 33	31 29	93 35	20 73	14 47
P.E.I./Î.-P.-É.	8	61,833	284 36	185 36	19 21	56 05	12 92	9 24
N.S./N.-É.	47	616,454	429 24	263 97	24 27	86 36	21 91	14 27
N.B./N.-B.	33	451,599	347 13	214 08	21 99	65 30	18 75	11 34
Qué.	173	4,233,266	326 12	219 83	23 17	60 91	12 18	10 00
Ont.	221	6,249,103	395 09	245 80	25 49	76 61	17 76	13 56
Man.	80	734,423	427 42	256 83	26 17	98 57	17 21	12 30
Sask.	129	562,552	295 00	190 31	18 64	57 32	13 31	9 36
Alta./Alb.	143	1,675,825	358 95	227 97	25 42	67 29	15 41	11 52
B.C./C.-B.	109	1,785,681	284 94	183 16	26 95	42 05	14 14	8 67
N.W.T./T.N.-O.	3	26,044	935 64	496 53	113 50	256 83	20 93	16 73

FOOTNOTES/RENVOIS:

[1] Operating expense includes medical staff salaries and fees (except Quebec) and salaries of interns, residents and students /Dépenses de fonctionnement comprend les traitements et honoraires du personnel médical (sauf pour le Québec) et les traitements des internes, des résidents et des étudiants

[2] Preliminary figures /Données provisoires

[3] Number of hospitals refers to the hospitals reporting total operating expenses /Le nombre d'hôpitaux se rapport aux hôpitaux qui ont rendu compte du total des dépenses de fonctionnement

SOURCE Statistics Canada /Statistique Canada See/Voir Index

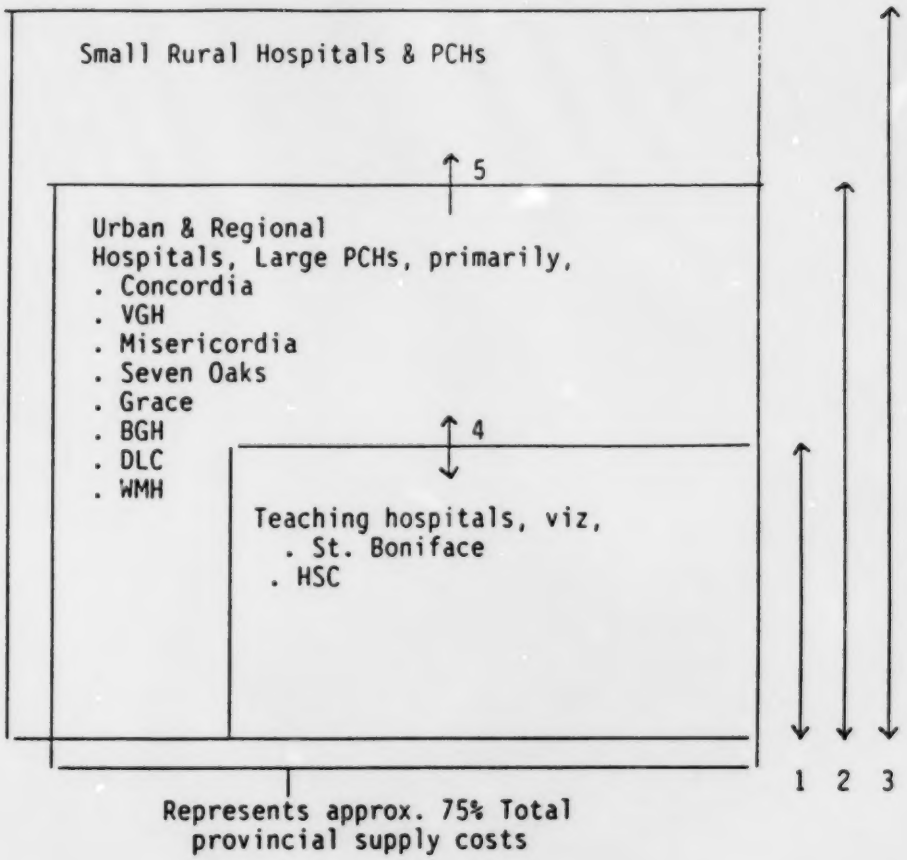
SUPPLY ANALYSIS 1989-90 ($MILLION)

Category	Estimated Total Provincial[1] Supply Costs	MHO[2] Contract Values	MHO Values Expressed as % of Total Costs
Medical/Surgical	42.98	6.74	15.7%
Drugs	22.20	6.71	30.2%
Radiology	5.84	2.62	45.0%
Laboratory	9.38	1.37	14.6%
Dietary	12.00	3.67	30.5%
Total	92.40	21.11	22.85%

1 Provincial totals extrapolated from actuals of 9 urban hospitals and based on (assumed) 75:25, urban:rural consumption patterns.

2 MHO total contract values annualized.

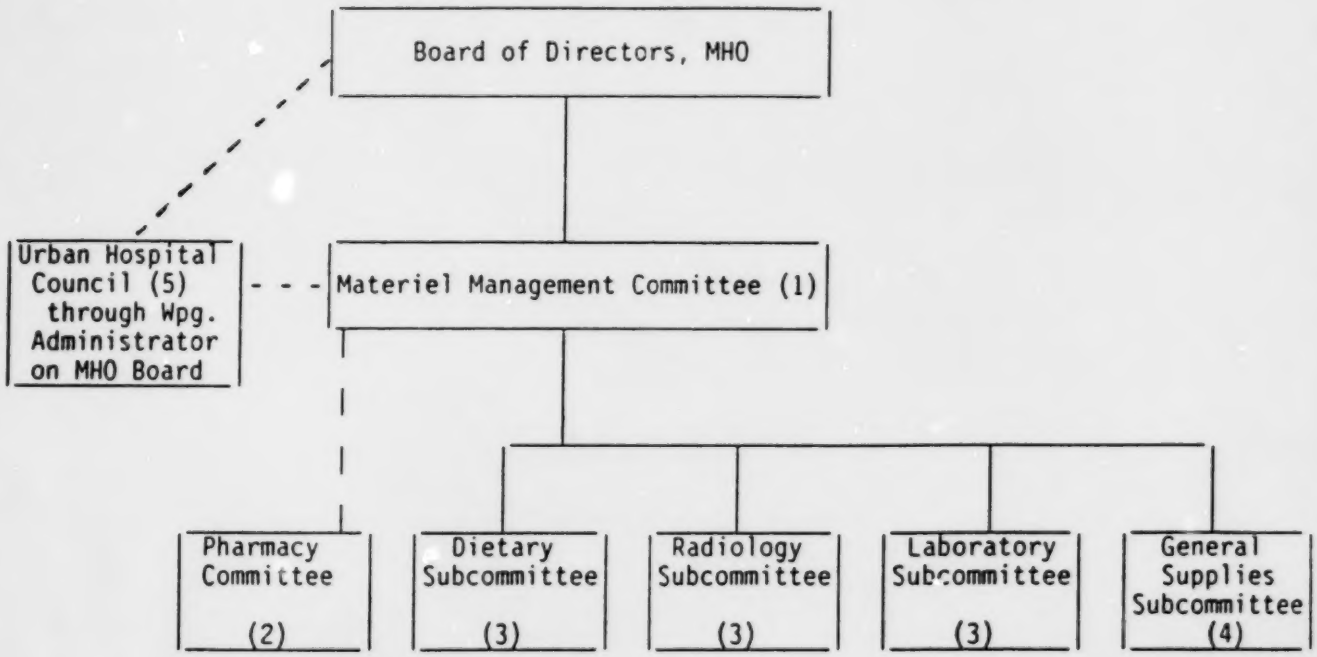
RESTRUCTURED GROUP PURCHASING PROGRAM



Notes:

1 Collaborative initiatives for tertiary program.
2 MHO program focussing on high value contracts/agreements for all 10 urban facilities.
3 Access to MHO program or regional supply program, based on contracts at (2). Note, benefits and expertise of group purchasing to be provided to rural acute and long term care facilities at minimum cost.
4 Communication re separately negotiated products that other group of facilities might wish to purchase.
5 Regional supply programs organized between a single large urban facility and small rural facilities.

PROPOSED COMMITTEE STRUCTURE


Board of Directors, MHO
Urban Hospital Council (5) through Wpg. Administrator on MHO Board
Materiel Management Committee (1)
Pharmacy Committee (2)
Dietary Subcommittee (3)
Radiology Subcommittee (3)
Laboratory Subcommittee (3)
General Supplies Subcommittee (4)

Notes

1 Committee composed of Materiel Managers from the 10 urban facilities identified at Appendix E.

2 Committee composed of pharmacists from the 10 urban facilities. Reporting relationship to Materiel Management Committee for coordinating purposes only.

3 All three subcommittees' composition remains at status quo.

4 Represents one or more subcommittees composed of Purchasing Agents with duties related to specific contracts as assigned by the Materiel Management Committee.

5 Acknowledges the accountability, authority and facility reporting relationships of the urban CEO's.

ADDENDUM TO THE
REPORT OF THE GROUP PURCHASING WORKING GROUP

TO THE URBAN HOSPITAL COUNCIL (UHC)

The Urban Hospital Council discussed the Report at its May 29, 1991 meeting, and suggested adding the following recommendations.

"Recommendation #7

Include (provincial) Mental Health Hospitals and Lab and X-Ray Services in the group purchasing process.

Recommendation #8

Qualitative assessment should take place prior to signing on with any vendors. In instances where new products are introduced, pilot projects should be placed in a few hospitals prior to new products being added to the group purchasing list.

Recommendation #9

A Central Product Review Committee should be established to initiate pilot projects and standardization. It was requested that Hila Willkie report back to the Urban Hospital Council with recommendations on the value of the Central Product Review Committee. The annual budget for group purchasing should be approved by the Urban Hospital Council, and program administration costs reviewed by senior executives once or twice a year prior to being presented to the MHO Board."

In addition, their discussion revealed interest in:

- adding the Materiel Manager, Dauphin General Hospital to the Materiel Management Committee; and
- recommending a mechanism for the Materiel Management Committee to report to the MHO Board.

The Working Group, after careful thought of the Council's feedback, submits the following response to their concerns.

RESPONSE TO UHC RECOMMENDATIONS

1. **Investigate the operational and financial feasibility of government agencies' (eg. Brandon Mental Health Centre, Laxus) participation in the MHO program.**

   Presently participation in the MHO program is limited to active and associate members of the association. Based on that requirement, agencies such as the Manitoba Development Centre and Laxus would be ineligible to join. Furthermore, government-mandated operational constraints, such as a

was the advantage of wider input, but in view of the small total volumes purchased by and through the Dauphin facility, it was determined that this would defeat the original principle underlying the program's new governance structure.

It was recognized that a liaison link was important between the program and its rural participants and this link could be effectively established through the Manager's position. This would ensure that their concerns regarding supplies and suppliers could be addressed. In addition, representation on negotiating or evaluation subcommittees could be solicited for situations where a rural facility is the dominant purchaser of a particular product eg. Thompson General Hospital with respect to fuel oil.

4. **Establish a reporting link between the Materiel Management Committee and the Board of MHO through the Winnipeg Administrative representative to the Board.**

The elected administrative representative to the Board of MHO is, ex officio, a voting member of the Urban Hospital Council. The joint accountability of administrators and their materiel managers for program performance and the integral role of the Council in monitoring the program are the two factors that provide the administrative representative with information to ensure knowledgeable reporting to the MHO Board. To ensure communication and understanding of the issues and direction of the Materiel Management Committee, the administrative representative should routinely receive minutes of committee meetings and periodically meet with the committee, its elected chairman and/or the Manager of MHO's program.

The use of existing relationships will facilitate convenient monitoring by all stakeholders.

IMPLEMENTATION PLAN

There are no additions to the original plan.

CONCLUSION

The working group was able to integrate the intent of the Council's feedback into the reorganized program and is available to answer any questions that arise.

Respectfully submitted,

Hila Willkie (Chair)
Bryan Hill
Mike Kirkpatrick
Garth Moreland
Tom Woodward